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We deliver our children - in pain?

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We deliver our children - in pain? with pleasure?

Bernike Pasveer and Madeleine Akrich

Introduction

Childbirth is always assumed to be a very emotional event in a woman's life.

Emotions can vary: they concern a woman's transition to motherhood, joy and other pleasures, and also pain related, for example, to a woman's relation with her mother, to contractions of the uterus, to fears of leaving one's own childhood behind, etc.

These emotions and sensations are also assumed to be private, embodied, subjective, like skills: performed, assumed to exist without being readily explicable. "She [the woman, bp] is totally absorbed by what she experiences; nothing else counts, nothing can disturb her. It is as if she has eruggetrokken in her own separate circle. She knows exactly what to do, she does not need instructions, because she is totally tuned to her body and to the energy that **golven through** her with coming and going urge to push the child out." (Kitzinger, in Odent 1984, p. 8). They belong to and exist inside a person, in a subject which is whole and separated both bodily and psychologically from others.

Elsewhere (Akrich & Pasveer 1996, Pasveer & Akrich 1996) we have argued that women's bodies and competencies are being distributed according to and in collusion with specific obstetric settings. Here we want to suggest that the emotions and sensations that would occur during birth - always assumed to reside in a single, personal body-subject - too are rendered (in)visible and (in)existant in specific ways. As traces of the birth process are being produced by many different participants, so may emotions and sensations. Our point is that given the claim of obstetrical care-givers that birth is a centered and as such highly important event for women as whole persons, it makes sense to study to what extent and how this claim is materialized in birth settings. We assume and argue that sensations, emotions - the domain of psychologists and neurologists mainly - result from specific sociotechnical practices. This does not imply that other professionals studying joy, desires, pain, speak nonsense. It does imply, however, that it makes sense for anthropologists/sociologists of technology too to study such private parts.

We hope to suggest that this attempt at a re-description/re-ascription of sensations - we focus on labour-pain - enables us to question widespread assumptions about labour and labour-pain. These assumptions all are driven by the same conceptual engine in which human bodies and most of human sensations are clearly delimited and separated, individual experiences. Modern obstetrics, in its high-tech forms (as practiced for example in France, but in many other countries) as well as in its 'natural birth' variants (as practiced in The Netherlands), tends to legitimate all of its practices partly in terms of them being constitutive for this single subjective bodily and personal experience. Thus epidurals, infusions, home-birth with a midwife, no ultrasound check-ups or one every month, monitoring, anything, are being practiced and propagated all on the same grounds. They are put into place or left out, because they 'set free' this lonely, individual subject with her own body/mind to give birth to a baby. We wish to challenge this assumption, for two reasons: one is to be able to show how assumption and practice/materialisation might be rather different. The other is to be able to suggest that it might make sense to do this as

We will show that any organization of birth states or assumes sensations to be, to reside in places and present themselves in ways that collude with obstetrical specificities. We do not wish to suggest that women 'themselves' are excluded from these regimes! There are many indications, for example, that women themselves are active supporters of technological childbirth. De Vries recounts efforts of the 'natural childbirth movement in the US in the 1970s and 80s: 'We expected opposition from physicians and hospitals, but we were not prepared for either the resistance or the apathy we found among the very women we wished to help' (De Vries 1996: xii). The right for pain-suppression during delivery in various countries (notable Sweden, the UK, France) has been granted partly as an answer to women's demands.

Nor, however, does it imply that women's emotions entirely overlap with 'organisational' ones.

What we wish to show here is that sensations spread out of subjects/persons or are attributed to subjects/bodies in collusion with an obstetrical scenario, or are different from single centered bodies and subjects. In a sense, our paper colludes with that of Moser and Law (this volume). Without going into the politics of those who hail the distribution of subjectivity, who praise the disappearance of 'the centered subjectivity of arborescence' (Moser and Law, 1998, p. ...) our argument colludes with their worries over resultings states of distributedness. It will become clear from our story that the different distributions of sensations in the settings we describe do not lead straightforward to 'freedom of choice' for one or another combination of subjective embodiments. Maybe this is so because the body is involved in the cases we describe, whereas for philosophers like Deleuze it would be a less important parameter (if we may use this word). But maybe it is so because we study configurations in which sensations, emotions, subjects are being produced rather than thinking of abstract philosophical categories and the way they crumble. Who knows?

We proceed as follows. We show two schematic drawings of deliveries, or rather of the constellations in which childbirth take place. The first is a French hospital birth, the second a Dutch homebirth. The drawings are made on the basis of various sources on birth in both countries: scientific and popular publications on childbirth, videotapes of birth, interviews with ‘new mothers’. We analyse the two images in terms of the various contributing actors depicted. We say who or what they are, and how they are supposed to contribute to the delivery. We then re-configure pain in the event: we show where it is supposed to be, and why this is so.

What appears in this way is ‘pain’ (present, absent, mixed with other sensations and emotions, suppressed, distributed) as a result of a particular setting rather than as pre-given, present, one sensation in one body/subject.

We conclude by arguing that pain is radically different things in these configurations, and by indicating what this might imply for assessments thereof. That pain has no potential presences as a centered sensation in the French setting. And that it has no potential presences as a single, separable sensation in the Dutch setting. As soon as pain becomes visible in the French setting, it centers a woman and this cannot be handled. As soon as it does in the Dutch setting, it singles pain out from the other sensations and then de-centers woman in a way that is hard to combine with the projection of woman as body-and-mind in one.

Birth in a French setting

picture I

We see: woman, uterus, fetus, sphygmometer, epidural, urine-catheter, partner, woman’s eyes, midwife, midwife’s fingers, infusion, monitor. We try to describe them separately, but as will become clear, the various participants have all sorts of mutual dependencies. Take one of them away, and the whole setting has to be architected anew.

Uterus performs contractions. It is located inside the woman's body. Uterus' work of contracting is crucial to vaginal birth. Tendencies that may lead notwithstanding (percentages of caesarean sections increasing everywhere), vaginal birth is still preferred in most settings. Contractions are caused by a hormone - oxytocine - which originates in the woman's body. However, as this bodily-produced hormone does not always make for regular and (equally) strong contractions, its function is delegated to an infusion which administers this oxytocine in regular and calibrated amounts. Uterus' work is registered by two, maybe three or four, other participants: midwife, monitor, woman, partner.

Midwife can often see from a woman's behaviour when a contraction is coming, but she also watches the monitor-trace to see a contraction, its force, duration, and the (re)action of the fetal heartbeat. She also surveils some of the other participants: infusion, sphygmometer. Midwife also check the delivery's progress with her hands/fingers: every now and then she does an internal examination from which she then knows the number of centimeters of dilatation. When dilatation is some 9 to 10 centimeters, she can tell the woman that if she or the monitoring feel like it, she can/must start pushing. Which then concerns another of midwife's activities: she encourages woman during labour and in particular during the expulsion to push well. If the delivery takes place under an epidural (see below) and woman senses no forceful urge to push, midwife must infer from the monitor trace that a contraction is on its way, and woman must push on command of the collective actor called midwife/monitor.

Monitor is an extremely crucial agent in this setting. It is put into place for safety: to see whether the baby is doing well under the storm of contractions. But its presence knows many more legitimations. Its paper trail is a continuous translation of fetal heartbeat and uterine activity. If an epidural is in place, it is the prime registrar of

contractions - but is also often is this when a woman does feel contractions. Thus it is a wellknown event that midwives, but partners as well, tend to watch the monitor-trace intensely and use the trace to announce to the woman that a contraction is coming. For it appears that the monitor registers a contraction before the woman does. An effect of this agent is that women's registrations of labour (if she has them) become less important as obstetrical parameters.

Woman, of course, is a central entity in all birth settings. There is a baby inside her, and this baby must be born. Woman lies on a bed, and she is connected to all the other participants: infusion, monitoring, midwife, partner, uterus, fetus, epidural. Her contribution to the delivery is connected to or even constituted by theirs. So she 'surveils' the monitor, and physically behaves so as to enable its sensors (both applied to her belly, or one to her belly and one to the head of the baby) to trace the baby's heartbeat and contractions. If an epidural analgesia is in place, woman is to push on command at the expulsion stage. During labour she can do as she likes as long as she stays where she is, for no sensation of contractions and labour regulated by the infusion implies a reduced need to concentrate on embodied contractions. Women read, chat with their partner, think of their babies or of motherhood, but they also report to have been left alone too much during labour. This might be seen as an indication of the 'negation' of woman as a centered being: if all the work of her body is registered elsewhere, if, moreover, the pain produced by contractions is suppressed by a local anaesthetics, there is no person left who needs 'personal' care.

Which leads us to the last participant to this delivery: the *epidural*. This is a local anaesthesia administered by an anaesthesiologist at any point during labour, and which renders numb the woman's lower half of the body. The effect is that sensations of contractions (almost) disappear. Contractions are assumed to be physically (very) painful, and therefore dangerous, or distracting (from concentrating on the event of becoming a mother etc.), or just too painful to handle in this particular setting.

As we have argued elsewhere (Akrich & Pasveer 1996, Pasveer & Akrich 1996), the difficulty of handling pain presents itself simultaneously for the woman and for the configuration in toto. Rendering pain invisible/absent is equal to making the configuration work. Present labour/pain often requires a woman to move, which will then cause the monitor and some of the other apparatus to malfunction. Present labour/pain sometimes requires a woman to moan or cry, which is said to be disturbing the serene atmosphere which must accompany the birth-process. Present pain also seems to require support from others, and apart from partner there are no such others available in this setting - apart from the epidural that is. It must be said, however, that the very discourses of pain that we use here, differs from its place in the Dutch setting. In the French setting, it is assumed that pain occurs on its own, as a separable sensation during labour, and that taking away the pain allows for other sensations to present themselves fully yet undisturbingly for the accomplishment of the delivery.

Women who wish to try to give birth without an epidural in a setting like the one described here sometimes report that they managed to show no signs of labour/pain: they managed to render pain just as invisible as it would have been under epidural.

"I asked for an epidural myself. That was no problem. Or rather I should say they more or less sell you the epidural. At a meeting with the anesthetist on the epidural he said: 'the epidural is great ...' But I was not sure whether I wanted one. But once in hospital, the atmosphere ... there was this woman with whom I shared the pre-labour room and on whom the epi did not work, and she was crying so hard, I thought: OK, if you want an epi, you'd rather have it right away. But yes, in first instance I belong to those who don't know. I was so self-confident. I had had this very good preparation, really very good. So I was confident. Now that I come to think of it ... the atmosphere in this hospital During a preparation meeting we 'doubters' had been warned: you will not be welcomed warmly. Which is exactly what happened. I said to myself: if I am not supported, if I am not encouraged, then I cannot do it, I will not be able to keep myself together and remain quiet. If they had received me friendly, I would have been able to do without an epidural".

A final word about the staging of *partner*. Partner is deliberately drawn a bit small-size and to the margin. In the French setting, his (her) presence is preferred for personal or relational reasons, but in obstetrical terms he (she) is not needed. Of course his (her) presence may be a support or comfort to woman, but it is configured by professionals to be connected only to the psychological event of becoming a parent, not to the obstetrical event of giving birth.

The event of birth is thus clearly set in obstetrical/medical terms. The delivery is performed by a rather hybrid collective. In this collective that which is obstetrically important is 'taken out' of the woman's body and rendered explicit and visible as machine-traces, surveilled by midwife and apparatus. Obstetrically relevant parts of the delivery are explicated as such and achieved with various participants as centers. Thus the event has no single center. Nor does it presume - it would rather not - or support a single center. Woman as a centered and embodied subject has no obstetric relevance - rather the presence of such an entity would be a nuisance to the event. Only those sensations that are no obstetrical parameters in this setting (the joy of becoming a mother, bonding with the newborn, etc.) can be present. Or, stronger, an important reason to put the apparatus described into place is to allow woman to concentrate on future role as a mother.

Pain in a 'French' setting

Now where is pain in this collective entity that performs the delivery?

Birth is accomplished by the many participants collectively. In that setting, only those 'subjective' sensations which cannot or need not make a detour and need not be distributed and surveilled by others, only these sensations have a potential presence. It is, however, quite unclear whether women experience these 'subjective'

emotions (of binding with their baby, etc.). We have shown elsewhere that although women are supposed to be 'centered' in psychologically, the setting often disturbs this potentiality. For example, babies are often taken away for their ritual bath quite quickly after birth, and women who should then be completely 'ready' for motherhood and bonding are left alone disappointed.

There is no room for the presence of pain in/out the woman in many ways, for there is no room for 'woman' as a centered obstetrically relevant entity. Rather, she is part of the apparatus in which birth is performed/takes place, and in this apparatus she performs only what is constitutive for the performance of the collective. Pain is not, *for it centers her physically*, and this cannot be handled. She must lie still, be serene, pain is dangerous, she herself is prepared for pain as an unbearable phenomenon, and the organ that makes pain contracts as a result of administered hormones, and produces its signs of labour as a paper trail. This renders felt labour/pain redundant as an obstetrical parameter, and a nuisance for the setting.

Birth in a 'Dutch' setting

picture II

How are things here? Who participate to the birth of the baby, and how?

Some entities that participated in the French setting, we see here too, but not all. We have uterus, midwife + hands/fingers, woman (partners, both the French and the Dutch, will appear in the conclusion). We also have doppler. Monitor, infusion, bloodpressure-meter and epidural are absent in this setting. Pain is present, but in a different way than 'present/suppressed' pain in the French setting. We shall see why this is so, and what this implies in terms of labour/pain.

Uterus performs contractions. The organ contains the baby, and it is located inside woman's body. Contractions, we read, are induced by a bodily produced hormone called oxytocine. This production is unstandardized and irregular. In the Dutch setting

this bodily produced hormone is taken to be productive enough for 'good labour'. Thus, uterus is the only performer of contractions here. Its work is registered as embodied by woman, midwife and maybe partner too. To know whether uterus contracts, the only sign is the woman('s body).

Midwife has a complex role in this setting: she knows what is obstetrically relevant and she also is taught that it is obstetrically relevant to keep this knowledge invisible as much as possible. In practice this means that she is supposed to organize or to contribute to an atmosphere of de-tension which is then productive in obstetrical respect.

Here is what she does. With her fingers she checks dilatation. With doppler (see below) she checks the baby's heartbeat every now and then. If dilatation is complete, she guides the expulsion on command of contractions in uterus as reported by woman (in the form of body language or of a verbal announcement). Midwife registers contractions through her - she has no other means than to watch and listen to woman. Her presence is discontinuous during labour: she comes, checks dilatation, fetal heartbeat and 'atmosphere', and leaves. As the expulsion comes near, she stays present.

The Dutch partner is drawn a bit bigger, and closer to woman, than his French companion. And there are also more connections between woman and partner that contribute to the obstetrical performance of birth. Partner is here supposed to contribute to the atmosphere that is constitutive for 'good labour': calm, comfort, etc. He does not perform any clearly circumscribed obstetrical or other tasks (although the ritual of co-breathing through contractions has become fashionable these days: partner sitting close to woman and as a contraction presents itself and the woman is to perform a learned breathing technique (puffing), partner does that with her) - he (she) is present and supports woman in any sense.

Doppler is a little digital ultrasound devise, with which the fetal heartbeat can be made audible. Most often, midwives use an amplified version of the instrument so that woman and partner are able to hear it too. Doppler is used with intervals during labour and expulsion. It leaves no paper traces. Thus fetus, in the form of its heartbeat, does make a little instrumental detour, but is 'put' back quite quickly.

Woman is literally the center of the event. She registers (whether she likes it or not) contractions, their frequency and force. She is required to remain 'together': not to panic or to flee from contractions. She must concentrate on labour, 'dive into' contractions, and her environment (room, partner, midwife) must behave so as to encourage her to achieve this concentration. She must be and remain one person, one body. Woman is required to support labour/pain, for no anaesthesia can be administered at home-birth: an epidural requires an electronic surveillant and midwives do not carry monitors with them. Labour/pain has many potential and actual presences in this setting - but it is conceived of and women are assumed to experience it as almost inseparable from other emotions and sensations.

Pain in a 'Dutch' setting

We see that the home-birth setting configures quite another distribution of obstetrical competencies. As these competencies are supposed to be best performed when kept 'inside' the woman's body, and when kept as implicit and unseparated from other emotions, sensations etc., all participants in this setting strive to stage woman as a centered subject with a clearly circumscribed, private body.

To this end, midwife's role is crucial. Ideology/practice has it that obstetrical/medical knowledge is to remain incorporated and implicit wherever possible. Rather than being excorporated, explicated, and passing through a series of apparatus, as in the French setting, it passes from woman's body/talk to midwife's

body/talk and back. It is kept in bodies and as implicit as can be. However, its potential visibility is enormous given the double agenda of midwife: her encouragement, presence, calm, etc. are obstetrical parameters as well as socio-psychological ones. As soon as midwife registers a problem, obstetrics can be visualised almost immediately.¹ But as long as all goes well, the key task is to configure the centered subject, the single body, as competent of giving birth 'on its own', sometimes even 'instinctively, without the detours of surveillance and encouragement and disembodiment characteristic of the French setting. Dutch obstetrics is often characterized as 'expectant'. It might qualify as such when it comes to instrumental interventions; it would qualify less as expectant with regard to the policy directed at preventing such interventions to occur: Dutch home-birth too is a highly staged event, in which those who participate are required explicitly to act so as to keep in place this single, concentrated body/woman/uterus.

In the Dutch setting, then, pain performs a peculiar role. It is staged as a centered, but also as a mixed, sensation during birth. Centered, as it is inside a body, it cannot be taken out or suppressed, and everything must be organised so as to enable this body to manage labour as incorporated. Mixed, as pain is not staged as an isolated physical sensation. Rather, labour-pain is said to be different from other pain as it is inherently connected to the experience of birth as a special, spectacular and formative event. 'You will see that giving birth gets you into an entirely different mood than your normal life. All happens as if your body with its strong contractions, its pains, tells you: attend me, attend only me! It is clear that you need this concentration during the delivery, this closing-up **refermement** in yourself, in order to be able to enter into this new stage of life' (Spanjer et.al, 1994: 131)

¹ I should explain this: Dutch homebirth takes place as the center of an onion-like structure: in it, and around it, and mobilizable at any instant, is specialized care. In it, as midwife carries with her a series of devices that can be used in case of emergency. Around it, as women may give birth at home only if a hospital is within reach of 30 km, and only if they are considered (according to a list circumscribed criteria which is used by 82% of midwives, see TvV april 1998) to be at 'low-risk' of pathology occurring during birth.

As in the French setting, the ability to support labour-pain is carried by the whole apparatus. As soon as this apparatus falls apart (for example when the fetal heartbeat slows down dramatically or when significant bleeding occurs, but increasingly also because of a rather vague indication called 'slow progress of delatation'), we see 'woman' fall apart, and therewith her competencies to be the person whose body gives birth. At such points, labour-pain often becomes hard to bear/a nuisance. For instance, a woman has laboured at home for some 24 hours without having complained much about pain - but about uneasiness, discomfort. The midwife comes and measures hardly any progress of delatation, and proposes to go to hospital to maybe administer oxytocine. Once inside the hospital, lying on a bed and all nerves, the woman asks for something to reduce the pain. One might, of course, say that all the time at home she had been dying from pain. One might also say that pain can be separated and even felt as a separated sensation once the centered woman has fallen apart, as it were, once it is clear that this entity is *not* going to give birth 'on her own'.

Thus if pain is made explicit as a separate and distinguishable phenomenon - as soon as a woman is in pain *only* - something has gone/goes wrong. First, isolated pain can only be suppressed in hospital with an epidural, which implies the end of the event of home-birth, of course. Second, pain is implicitly - but less and less so - taken to occur as part of a complex of emotions and sensations that cannot or should not be disentangled. It is assumed that if women are well prepared and courageous, pain does not pop up out of this range of sensations that accompany birth: sadness, joy, fear, pain, concentration, trance, whatever. So in the Dutch setting, it is the presence of pain, or rather the impossibility and counterproductivity to suppress it/render it invisible, that is important.

Here we see labour/pain as inseparable and necessary. And as in the French setting, the specific role of labour/pain is said to support both the performance of every specific delivery, as well as institutionalized obstetrics. For it may be clear that

in this country a practice of separating, decentering and then suppressing pain with a local anaesthetics during birth would require all of the setting to be reordered.

Conclusion on birth and pain

So we see that both settings treat labour/pain rather coherently. In the French setting, birth is performed by a collective and birth-knowledge and skill does not reside in one clearly circumscribed woman's body. In so far as it concerns obstetrically relevant parameters, woman is not a centered, embodied subject. To the extent that she is, this concerns 'psychological' aspects of giving birth, skills of intense joy, becoming a mother, bonding with the new baby etc., for which there appears to be more room in a setting in which woman is not preoccupied primarily with her body.

The presence of pain as an embodied phenomenon can be managed if woman manages to behave as if labour does not hurt. Otherwise, there is no room for such an explicitly centered bodily sensation.

In the Dutch setting too, labour/pain is configured rather coherently. Birth is deliberately staged as an embodied event, and all participants are required to attribute to this staging. Birth is performed by a woman/a body, birth-knowledge is embodied by midwife and woman, and knowledge about the process passes through their bodies. Only in specific cases is this knowledge excorporated and thereby rendered visible, explicit. Woman is her body, is a centered subject. Neither physical sensations nor psychological processes - if we may distinguish them for the moment - are explicated, at least not for long lasting periods of time. So in the Dutch setting, women's crying, moaning or other expressions which would in the French setting be 'read' as signs of pain immediately, are not interpreted as such. It is generally held that there is a certain, small, percentage of women who suffer from 'pathological pain' (for whatever reason), but that women suffer most from intense pain as a result of not being at ease,

sitting/lying in an unfavourable position, or are at the stage of transition [from delatation to expulsion, bp] and are about to give birth. For the first category - it is unclear how one might detect them - an epidural might be good practice. For the others, it is either a question of rearranging the existent setting to as to reduce the experience of pain-only.

What cruelly. Yet, in both kinds of settings, most women report having valued highly the event of birth. Yes, it was painful, but it was extraordinary. One forgets the pain and remembers the rest, you know. Yes, it was a nuisance to be strapped to a bed and tied to all these machines, but it was worth it, and it was a pleasure not to be in pain. But still: we see incoherences in both settings. Incoherences which need not last in women's memory, but which occur as they tell their birth stories. Or which may occur as one thinks of changes taking place in obstetrics.

We mention some of these occurring incoherences. Pain is not something you do or do not take away: it is staged as a specific sensation which is highly coherent with and constitutive of both kinds of settings.

It follows from our argument that attempts - whether made by obstetricians/government or women - at rearranging obstetrics would not only have to concern techniques and safety, but also the explicit staging of sensations, and of pain as a crucial one. In France, the tendency is to start selecting women according to specific criteria and then arranging a kind of one-to-one birth-configuration. Thus a high-risk woman would deliver in a setting which is prepared for grave pathology, whereas a low-risk woman would give birth in a setting less obviously structured 'to avoid the worst.' This latter setting would then re-arrange and probably also delete certain of the participants described. Following our argument of the coherence and mutual constitutiveness of the setting's participants (including (absence of) labour/pain), one would have to think out loud about new distributions of competencies - including the competency to manage labour/pain in the setting. For

one does not simply administer the epidural or not: its presence or its absence involve a highly different woman, a radically different setting.

For the Dutch setting, the argument would be slightly different. Here the tendency is to, as it were, reduce the importance of selection and to give birth in hospital increasingly. It is not always clear why this is so in specific cases (we mentioned the increasing percentage of slow progress), but accompanying this tendency towards the hospital and specialized care at birth, we also see percentages of epidurals and other obstetrical interventions increase. For one thing, we would argue against the thought that a hospital birth without interventions is just a displaced home-birth. It follows from our argument, but also from other studies, that the very visibility of new participants involves a rearrangement of expectancies and of competencies. It so appears that Dutch midwives who do a policlinical birth indeed tend to arrange for more technical and specialized check-ups than they would have had the woman stayed home.

We would suggest that as women's trajectories during pregnancy become more and more complex - a blood test here, an ultrasound there, this midwife and that that - their experiences therefore become spread over more places and actors. It is far from obvious that such increasingly distributed trajectories are compatible with the centered, embodied and self-registring woman during home-birth.

Of course, there is much more to say about these tendencies. We have tried here to argue that sensations, desires, emotions, all the experiences which are said to occur during birth but which tend to, as it were, appear unstaged during childbirth, are radically different and strongly related to the birth setting which is put into place for women.

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